

PROOF OF ACCIDENTAL DEATH—CLAIMANT STATEMENT
(Attach Original Death Certificate)

1. Complete name of Deceased _____ 2. Date of birth of Deceased _____

3. Residence of the Deceased at death

(street) (city/town) (county/region) (post code)

4. Place, date and time of death _____

5. (A) Occupation of Deceased at death _____

6. Where did the accident occur? _____

7. How did the accident occur, if this was a motor vehicle accident, confirm the type of vehicle involved?

8. Please confirm cause of death if known and injuries sustained? _____

9. Was a Postmortem or Inquest held? _____ If yes, give the name and address of the Coroner / Procurator Fiscal and attach a copy of the report if available to you.

10. Were the police called to the scene of the accident? _____ If yes, give the name of the station and contact number for officer involved. Attach a copy of the report if available.

11. Did the Deceased have a family doctor? If yes, give the doctor's name and address. _____

Stonebridge International Insurance Ltd is authorised and regulated by the Financial Services Authority

Stonebridge Claims Handling Unit, PO Box 2801, Stoke on Trent, ST4 9DN.
Tel: 0870 420 1244 Fax: 0870 420 1180

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12. Did the Deceased carry any other Accident or Life Insurance? _____ If so, state name and address and amounts carried.

13. (A) What is your full name? _____ (B) Date of Birth _____

(C) Relation to the Deceased? _____

14. Any additional relevant information

I declare that the above statements are true and complete to the best of my knowledge and belief.

I understand that any fraud, mis-statement or concealment found would cause this policy to be of no effect and all legal rights to benefits and any premiums paid will be lost.

On behalf of the deceased's estate, I now authorise any Doctor who was consulted by or who treated the deceased to provide Stonebridge International Insurance Ltd ("the Company") or its agents with any and all information about the deceased. I also now authorise the release of any other information to the Company or its agent, which the Company considers relevant to enable this claim to be dealt with.

I understand that by furnishing this form and investigating the claim or by accepting any proof of death, the Company shall not be held to admit the validity of any claim or to have waived any of its rights in defence of any claim arising under the policy.

I understand that I may request to receive a copy of this authorisation. I agree that a photocopy of this authorisation is as valid as the original. I agree that this authorisation is valid for two years from the date shown below.

Data Protection:

Please note that we may retain and use the information you provide to process the claim.

The Company may also pass this information to its legal advisers, reinsurers, medical advisers or other companies we have instructed to validate the legitimacy of the claim, so that the claim can be fully administered.

This information may also be passed to other insurers, the Association of British Insurers or other regulatory organisations for fraud prevention and detection purposes and to validate the legitimacy of the claim.

I further understand that this information may be transferred outside of the European Economic Area by the Company or its reinsurer to the United States of America, in which data protection laws are not as comprehensive as in the European Economic Area, to assist the administration of the claim. By signing this declaration, I consent to the Company using and transferring this information as set out above.

Name in Capitals _____

Signature _____ Date _____

This form should also be signed by the personal representative(s) of the deceased, if different from the claimant(s)

Address _____

_____ Telephone No. _____

CERTIFICATE BENEFIT PAYMENT REQUEST

Important Notes:

- Neither the issue of this form nor the acceptance of this form once completed are admissions of liability by Stonebridge International Insurance Ltd.
- This form should be completed by the Claimant(s) as set out in the in Certificate of Insurance. If there is more than one Claimant, all Claimants must complete and sign this form before any payment can be made.
- The Claimant(s) should use this form to request how payment of any monies due to the Claimant(s) will be made, whether: (a) by direct transfer into the bank account(s) of the Claimant(s) or a third party; or (b) by cheque made out to a third party.
- If a request is made for payment by direct transfer to an International Account, the cost of this transaction will be deducted from the Benefit payment directly by the bank(s).
- You accept that by making a payment in accordance with your instructions, Stonebridge International Insurance Ltd will be discharging any liability we have to you under the Certificate of Insurance.

Please contact Stonebridge International Insurance Ltd if you are unsure as to who should complete this form.

Certificate Number(s):	_____
Name of Insured:	_____

In the event that the claim under the above numbered Certificate(s) is admitted, I/We request that the payment of any monies due to me/us be made payable:

To me/us/a third party, by Direct Transfer (please enter all details in BLOCK CAPITALS):

Name and Address of Bank: _____

Bank Account Sort Code: _____ / _____ / _____

Swift / IBAN Number: _____ (International Payments only)

Bank Account Number: _____

Name of Account Holder: _____

To a third party by Cheque (please enter all details in BLOCK CAPITALS):

Name of third party _____

Address of third party _____

Signature of Claimant(s)	Name in Capitals	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____